Arizona Department of Health Services
Methicillin-Resistant *Staphylococcus aureus* (MRSA) Surveillance
Supplemental Form (12/6/2004)

Complete this form if Methicillin-Resistant *Staphylococcus aureus* has been isolated from a normally sterile site.

Case's Name (Last Name, First Name):_____
Date of Birth___/___/_____ Race:_____ Ethnicity:_____
Address:_____City:_____State:_____Zip Code:_____

Residence/Location At Time of Onset:
□Home □Long Term Care Facility □Acute Care Hospital □Retirement Home
□Shelter □Homeless □Other, Specify_____ □Unknown

Date of Admission:___/___/_____ Outcome:___(1=Lived,2=Died,3=Transferred)

Healthcare Acquired □Yes □No (Community Acquired) □Unk

Disease(s) Caused By Methicillin-Resistant *Staphylococcus aureus*:
CHECK ALL THAT APPLY

□Pneumonia
□Bacteremia
□Ottitis(Media/Externa)
□Osteomyelitis
□Folliculitis
□Wound infection, Specify:_____
□Skin Infection,specify:_____
□Meningitis
□Bursitis
□Abscess
□Septic Arthritis
□Impetigo
□Cellulitis
□Other, Please Specify:_____

Date of Symptom Onset:___/___/_____ DNR? □Y □N □DK

Positive Methicillin-Resistant *Staphylococcus aureus* cultures:
Source_____Date__/___/_____
Source_____Date:___/___/_____

Categorization of Place of Onset/Population

□Yes□No□Unk Previously known MRSA infection or colonization
□Yes□No□Unk Hospitalized or in LTCF/Other Healthcare facility >2 Days before event
□Hospital □LTC □Other, Specify:_____
□Yes□No□Unk Chronic dialysis (hemo or PD) at time of event
□Yes□No□Unk Surgery within past year
□Yes□No□Unk Hospitalized or in healthcare facility within past year (but not prior two days)
□Yes□No□Unk Central venous catheter or other percutaneous device or indwelling catheter currently in use
□Yes □No □Unk Was the hospitalization intially due to MRSA infection?

Underlying Disease: □**Check Here If None**

CHECK ALL THAT APPLY
□Emphysema/COPD □Heart Failure/CHF □Alcohol Abuse
□Chronic Renal Insufficiency □Artherosclerotic Cardiovascualr Disease
□Current Smoker □Liver Disease
□Diabetes Mellitus □HIV/AIDS □Asthma □IVDU
□Chronic Dermatologic Condition □Psoriasis □Folliculitis
□Eczema
□Other Immunosuppressive Therapy_____
□ Malignancy-Solid Tumor Type:_____
□Malignancy-Hematologic Type_____
Post Operative□(Yes): Operative Procedure Associated With SourceDate___/___/_____
Procedure:_____(Code)_____
Flu Vaccine □Yes □No□Unk Date__/___/_____ (**For Pneumonia Patients Only**)
Susceptibility Method: **1=Agar**: Agar Dilution Method; **2=Broth:** Bacterial Broth Dilution; **3=Disk:** Bacterial Disk Diffusion (Kirby Bauer); **4=Strip:** Antimicrobial Gradient Strip (E-Test) **8=** MIC Result of unknown method **9=Unknown**

MIC Result: Enter the numeric MIC result (i.e.,>=2)
S,I,R Results: S=Susceptible; **I**=Intermediate **R**=Resistant

Antimicrobial Agent	Susceptibility Method	MIC Results	S,I,RResults
Linozelid			
Oxacillin			
Synercid			
Vancomycin			

Form Completed By:_____Date;___/___/_____
Facility:_____Phone:_____

Mail Completed Form To: **Infectious Disease Epidemiology Section**
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